PATIENT REGISTRATION AND HISTORY

PERSONAL INFORMATION

Patient's Name ________________________________ Sex (M or F) Marital Status _______________

Address ____

City ____________________________________ State __________ Zip _______________

Home Phone ___________________ Work# ____________________ Cell# ____________________

Email Address: ____

What is the best way to contact you? ____

Age __________ Birth date _______________ Social Security # ____________________________

Employer ____ Phone _________________

Address ____

City ______________________________________ State ________________ Zip ___________

In case of emergency, who should be notified ____

Who may we thank for referring you to us? ____

INSURANCE INFORMATION

Primary Dental Insurance ____

Name of Subscriber/Insured ____

Insured's Birth date _______________________ SS# or ID# _______________________________

Insured's Employer __________________________________ Group number _________________

I authorize the dentist to release any information including any diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers otherwise payable to me. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have received and read the Notice of Privacy Practices.

____ ____________________

Patient or Parent/Guardian Signature Date

ORAL/ MEDICAL HISTORY

1. Have you come to this office for the relief of pain? ❑ yes ❑ no
   If "yes" where is the pain?
   ____
   Have you had pain for more than 3 weeks? ❑ yes ❑ no
2. Are you happy with the appearance of your smile? ❑ yes ❑ no
3. Are you interested in changing the appearance of your smile? ❑ yes ❑ no
4. Are you happy with the color of your teeth? ❑ yes ❑ no
5. Do you suffer from bad breath or foul taste? ❑ yes ❑ no
6. Please check any items below that you use often in mouth care:
   ❑ hand toothbrush ❑ electric toothbrush
   ❑ dental floss ❑ gum stimulators
   ❑ toothpicks ❑ rubber tips
   ❑ other ❑ water spray
7. How would you describe your general health?
   ❑ poor ❑ fair ❑ good
   Date of last medical examination?____________________
8. Are you now being treated or have you been treated within the last year by a physician? ❑ yes ❑ no
9. Have you ever had an unusual reaction to dental anesthesia (gas or shots)? ❑ yes ❑ no
10. Following dental treatment, have you had bleeding problems? ❑ yes ❑ no
11. Do you smoke or use tobacco products? ❑ yes ❑ no
12. Do you chew ice? ❑ yes ❑ no
13. Do you grind your teeth? ❑ yes ❑ no
14. Do you drink:
    Coffee on a daily basis? ❑ yes ❑ no
    Tea on a daily basis? ❑ yes ❑ no
    Soda on a daily basis? ❑ yes ❑ no
    Alcohol on a daily basis? ❑ yes ❑ no

PLEASE CHECK IF YOU HAVE BEEN TREATED FOR:

❑ wisdom teeth ❑ TMJ (jaw joint disorder)
❑ braces, orthodontics ❑ dental implants
❑ periodontal (gum disease) ❑ root canals
❑ crowns, bridges

HAVE YOU BECOME SICK FROM OR SHOWN AN ALLERGY TO, OR BEEN TOLD NOT TO TAKE:

15. Antibiotics (Penicillin, etc.) ❑ yes ❑ no
16. Codeine ❑ yes ❑ no
17. Novocaine or other dental anesthetic ❑ yes ❑ no
18. Other drugs or medications ____________________
    ____
19. Do you have any allergies to latex? ❑ yes ❑ no

ARE YOU NOW TAKING OR USING MEDICINES FOR:

20. Diabetes (pills or shots) ❑ yes ❑ no
21. Nerves (tranquilizers) ❑ yes ❑ no
22. Sleeping ❑ yes ❑ no
23. Heart or blood pressure (digitalis, nitroglycerin, reserpine) ❑ yes ❑ no
24. Stomach trouble (ulcer or other) ❑ yes ❑ no
25. Aspirin, Advil or Motrin ❑ yes ❑ no
26. Arthritis or rheumatism ❑ yes ❑ no
27. Allergy ❑ yes ❑ no

ARE YOU NOW:

28. Pregnant ❑ yes ❑ no
29. Breast Feeding ❑ yes ❑ no
30. Using thyroid ❑ yes ❑ no
31. Using hormones (including Birth Control) ❑ yes ❑ no
32. Using Anticoagulants, Coumadin ❑ yes ❑ no
33. Using Dilantin ❑ yes ❑ no
34. Please list your medications: ____________________
    ____
    ____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

35. Heart Murmur ❑ yes ❑ no
36. Heart Disease ❑ yes ❑ no
37. Heart Attack ❑ yes ❑ no
38. Joint or hip replacement ❑ yes ❑ no
39. Rheumatic Fever ❑ yes ❑ no
40. High blood pressure ❑ yes ❑ no
41. Fainting spells, seizures, epilepsy ❑ yes ❑ no
42. Glaucoma ❑ yes ❑ no
43. Nervous breakdown, psychotherapy ❑ yes ❑ no
44. Lung trouble (TB, asthma, emphysema) ❑ yes ❑ no
45. Hepatitis, liver disease, jaundice ❑ yes ❑ no
46. Arthritis, sore joints, Lupus ❑ yes ❑ no
47. Diabetes ❑ yes ❑ no
48. Excessive bleeding ❑ yes ❑ no
49. Blood trouble, anemia, Leukemia ❑ yes ❑ no
50. VD (syphilis, gonorrhea) ❑ yes ❑ no
51. Radiation or Chemotherapy ❑ yes ❑ no
52. Blood transfusion prior to 1985 ❑ yes ❑ no
53. Tested positive for HIV (AIDS) ❑ yes ❑ no
54. Use of Prednisone Steroid ❑ yes ❑ no

Signature ______________________________

Date of Birth ______________________________

Physician's Name ______________________________